WRAP AROUND PROGRAM
Program Information Form
2020-2021 School Year

Child's Name:_____ Eye Color:_____
Skin Color:_____
Home Address:_____ Hair Color:_____
Height:_____ Telephone:_____
Sex:_____ Weight:_____Date of Birth:_____
Primary Language:_____Date of Admission:_____ Age at Admission:_____
Upcoming Grade:_____ School:_____
School Address:_____
Identifying Marks:_____
Allergies/special diet:_____
Important Information (i.e. adoption, foster placement):
_____

PARENT/GUARDIAN INFORMATION: Please fill out completely.
Parent/Guardian Name:_____
Relationship Child:_____
Home Address:_____Home Telephone #:_____
Business Name:_____Business Address:_____
Work Telephone #:_____
Hours at Work:_____Primary Email Address:_____
Cell phone #:_____

MEDICAL INFORMATION:
Parent/Guardian Name:_____
Relationship to Child:_____
Home Address:_____Home Telephone#:_____
Business Name:_____Business Address:_____
Work Telephone #:_____Hours at Work:_____
Primary Email Address:_____ Cell phone #:_____
Child's Physician/Clinic:_____
Medical Conditions:_____
Special limitations or concerns:_____
I certify that documentation of physical examination and immunizations in accordance with public school health requirements, and lead poisoning screening in accordance with public health requirements are on file at my child's school.

_____
Parents/Guardian Signature Date

WRAP AROUND First Aid and Emergency Medical Care Consent From
2020-2021 School Year

Child's Name:_____
Date of Birth:_____
I authorize staff in the Winchester Recreation After-School age childcare program who are trained in the basics of first aid to give my child first aid when appropriate.
I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to transport my child to the nearest medical care facility and/or
to_____ _____and to secure necessary medical treatment for my child.
Child's Physician Name: _____
Address:_____Phone number_____
Child's Allergies and Reaction:
_____
Medical Conditions: _____
Medications:_____
***********If your child takes medication an individualized plan must be filled out in order for your child to attend our Lynch after-school program .**
*****Emergency Contacts (in order to be contacted):**
Name:_____Relationship to Child:_____
I give permission for child to be released to this
Name:_____Relationship to Child:_____
I give permission for child to be released to this
Name:_____Relationship to Child:_____
I give permission for child to be released to this
1. Name:_____
Address:_____
Phone #:_____person? YES_____ NO_____
2. Name:_____
Address:_____
Phone #:_____person? YES_____ NO_____
3.Name:_____
Address:_____
Phone #:_____person? YES_____ NO_____
Health Insurance Coverage:_____
Parent(s) Name:_____
Parent/Guardian Signature person? DATE
YES_____ NO_____
Policy #:_____
Phone(w):_____Phone(c):_____
Phone (h):_____
Parent(s)Name:_____
Phone(w):_____Phone(c):_____

WRAP AROUND PROGRAM

(only needs to be filled out if your child has a health plan from his/her doctor)

Individual Health Care Plan Form

Plan must be renewed annually or when child's condition changes

Check all that apply by:
__Parent
__Doctor or Licensed Practitioner
__ Program's Health Care Consultant
__ Older school age child (9+ years of age)
__ Other:_____

Plan is maintained by:
__Director
__ Assistant Director
__ Child's Educator
__ Other:_____

Name of child: *Date:*

Any changes to the child's Health Care Plan?
Yes (indicate changes below) No (updated physician/parental signatures required)

Description of chronic health care condition:

Symptoms:

Medical treatment necessary while at the program:

Potential side effects of treatment:

Potential consequences if treatment is not administered:

Name of educators that received training addressing the medical condition:

Person who trained the educator (child's health Care practitioner, child's parent, program's Health Care Consultant)
Name of Licensed health Care Practitioner (print name)_____Date_____
Licensed Health Care Practitioner consent: _____Date_____
Parental/Guardian Consent:_____Date_____

For Older Children ONLY (9+ years of age)
With written parental consent and authorization of a licensed health care practitioner, this individual Health Plan permits older school age children to carry their own inhaler and /or epinephrine auto-injector an use them as needed without the direct supervision of an educator

The educator is aware of the contents and requirements of the child's Individual Health Plan specifying how the inhaler or epinephrine auto-injector will be kept secure from access by the other children in the program. Whenever an Individual Health Care Plan provides for a child to carry his or her own medication. The licensee must maintain a back-up supply of the medication for use as needed.
Age of child:_____ Date of birth:_____ Back-up medication received? Yes__ or No_____
Parent Signature:_____Date:_____
Administrator's signature:_____Date_____